Maryland
Hospital Association

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TASK FORCE ON HEALTH CARE ACCESS & REIMBURSEMENT

MARYLAND HOSPITAL ASSOCIATION (MHA) COMMENTS/RECOMMENDATIONS
SEPTEMBER 2008

I. BACKGROUND:

As the MHA/MedChi Physician Work Force Study showed, Maryland has 16 percent fewer physicians available for clinical practice than the national average. (See attached charts). The physician shortages are most acute in three regions of the state—Eastern Shore, Southern Maryland, and Western Maryland. And, these shortages are projected to worsen over the next seven years.

If the shortages are not addressed, consumers will face additional problems gaining access to care; experience increased waiting times to see a physician; and, face greater reliance on already crowded emergency rooms. A combination of short, intermediate, and long term strategies is needed to comprehensively address both primary and specialty care shortages across Maryland.

Enhancing reimbursement is absolutely fundamental/critical/essential to the effort. Today, Maryland physicians' reimbursement from commercial carriers is at the bottom 25 percent of the states, while medical liability insurance and other expenses have continued to rise in one of the highest cost of living states. And, the domination by two insurers in the Maryland market leads to a "take it or leave it" attitude in contract negotiations.

II. RETENTION:

HMO Balanced Billing (Options 3.1, 3.2)

- Require carriers to reimburse billed charges for services provided to an HMO enrollee by an out-of-network physician and hold the enrollee harmless for balance billing.

  Rationale: The current prohibition on balance billing in the HMO market effectively eliminates any negotiating leverage for non participating providers. It creates a ceiling for reimbursement and allows HMOs to establish arbitrarily low reimbursement rates.

  Shifting responsibility to the carrier to ensure providers are adequately reimbursed, while ensuring their subscribers are held harmless from balance billing, would correct this imbalance. Physicians would have a greater willingness to contract with the health plans due to a greater ability to negotiate a fair rate.

Prohibit Linking Hospital to Hospital-Based Physician Participation (Option 3.3)

- Prohibit carriers (creates an unfair trade practice) from linking hospital participation in a carrier's network to an independent physician's decision of whether to contract with the carrier.

  Rationale: Carriers contract with enrollees, in exchange for a premium, to provide an adequate network of providers. The carrier is contractually responsible for having an adequate in-network panel of physicians—including hospital-based physicians. Off-loading that responsibility creates an undue and unfair burden on the hospital and puts the hospital in the middle of what is the carrier's responsibility to their enrollees.

Facilitate Creation and Reimbursement for Medical Homes (Options 5.2, 8.1 8.3, 10.5)

- Encourage/require insurers to provide incentive payments to practices for technology upgrades/medical home development/expanded hours, etc.

- Use the Governor's newly established Quality and Cost Council to create a uniform statewide approach, with equitable funding, to assist physicians to establish patient centered medical homes.

- Apply for CMS Medical Home Demonstration Project.

  Rationale: The current delivery system is poorly prepared to meet the current and future needs of an aging population. Health care cost continue to grow faster that the economy, employers are cutting back on worker and retiree health insurance coverage and benefits, funding for the Medicare programs is being accomplished through cutbacks in services, decreasing reimbursement to physicians, and passing premium increases along to beneficiaries.

  Our system for reimbursement emphasizes episodic treatment for acute care. Care management, proactive or planned, active cross-discipline management, and even some preventive care are often uncovered services or are poorly reimbursed. Yet, 45 percent of the US population has a chronic medical condition and about half of these have multiple chronic conditions. For the Medicare program, 83 percent of beneficiaries have one or more chronic conditions and 23 percent have five or more chronic conditions. And, by the year 2015, and estimated 150 Americans will have at least one chronic condition.

  Development of a medical home model in Maryland presents an opportunity to change the reimbursement structure to demonstrate and acknowledge the value of coordinated, patient-centered, physician directed care that is enabled by health information technology and accountability for achieving measurable improvements in the quality of care provided. Fundamental to this effort is the provision of upfront funding to assist physician practices in instituting the infrastructure necessary to redesign their practices – similar to the CMS EHR demonstration project.

Engaging multiple payers in a uniform approach provides physician practices with greater incentives to participate. It would eliminate the practices having to put different systems in place for different carriers, could be used to provide funding for the upfront costs across a multiple payers, and may provide leverage for additional funding under the CMS Medical Home Demonstration Project.

Mental Health (Option 9)

- Require commercial carriers to pay primary care providers under the medical benefit for a reasonable number of visits per year, per condition to diagnose and treat mental health disorders.

  Rationale: The vast majority of adults with mental health disorders rely on their PCPs to make diagnoses and manage psychotropic medication. Over 25 percent of adults receiving primary care have a diagnosable mental disorder, most commonly depression and anxiety. While from a health care delivery perspective, treatment of less complex mental health disorders in primary care is appropriate and logical, from a work flow and a short-term financial perspective, there is less support for integration. The time required to diagnose and counsel a patient with a mental disorder is lengthier than required for most medical conditions.

  Because physicians treat patients from a variety of health plans and a given heath plan may only account for a fraction of the PCP's practice, physicians tend to manage their operations according to the overall composition of their payor arrangements. As a result, PCPs may avoid use of psychiatric CPT codes and submit claims with a primary diagnosis of "symptom codes" (e.g., fatigue, insomnia, etc.) or place the mental health diagnosis in a secondary diagnostic position. PCPs may also avoid use of extended service codes that compensate them for the longer visits required to manage mental health problems in order to reduce risk of claim denials.

- Require commercial carriers to coordinate the mental health and medical benefits.

  Rationale: The vast majority of Marylanders receive mental health coverage under the management of mental health carve-outs through managed behavioral health organizations (MBHOs). Insurance risk for mental health services is isolated from the overall insurance and covered in a separate contract between the payor (insurer or employer) and a mental health vendor with a distinct provider network and financial incentive arrangement.

  PCPs are typically not included in the MBHO provider networks and, therefore, are not paid for the providing mental health care under the mental health benefit or the medical benefit.

Physician Data Collection (Option 10.4)

- Enhance Board of Physician's licensure renewal data collection to include full time/part-time status; direct patient care as a percentage of practice time; specialty area, including areas of

concentration; whether currently practicing in Maryland, out-of-state, or inactive; use of electronic medical records, etc.

Rationale: Solid workforce projections are essential to assure Marylanders will continue to have access to the care they need.

Credentialing Simplification

- Direct DHMH to convene regulators, payors, and providers to develop procedures to streamline and standardize the physician credentialing process.

  Rationale: The physician credentialing process is an extremely time-consuming, detailed, and labor-intensive process for all parties involved. Physicians in Maryland often apply for privileges at multiple facilities and/or carrier panels. The data collection process is fragmented, duplicative and uncoordinated, creating unnecessary and overlapping burdens on both the physician applicants, as well as those performing the credentialing activities.

Aggressive Enforcement of Network Adequacy Regulations

- Direct the Maryland Insurance Administration to monitor carrier network adequacy standards aggressively in shortage areas.

  Rationale: Effective this fall, Maryland Insurance Administration regulations will require carriers to demonstrate an adequate "network" of providers to meet the needs of their members.

Pilot Voluntary Reimbursement System for Emergency Physicians (Option 5.1)

Need consensus among hospital-based physicians as to the desirability of such a system at this time.

Medical Liability

- Recommend enactment of Good Samaritan protection legislation for physicians practicing/providing consultation in the emergency departments.

  Rationale: Would facilitate appropriate on-call coverage in the emergency department.

- Recommend enactment of apology protection legislation.

  Rationale: Would facilitate quality and patient safety improvements.

- Require medical liability insurers to provide additional mechanisms for Maryland physicians to institute risk management strategies in exchange for premium reductions; i.e., telemedicine, EMRs, chronic disease management, medical home designations, etc.

  Rationale: Investments for technology upgrades that enhance patient safety and improve patient outcomes reduce liability risk.

- Require medical liability insurers to offer retired/part-time physician policies that do not require "tail" coverage.

  Rationale: Provides flexibility/incentives for retired physicians to practice part-time.

Oversight of P4P Programs (Option 4)

- Require carriers in their filings to the MIA to define high performance plans based on factors that include more than just costs.

Rationale: This would provide additional transparency as to what carriers are expecting of providers and would enable the MIA to track trends in carrier P4P programs. These programs should be focused on rewarding and enhancing quality and better health outcomes. They should not be focused on penalizing providers who are already under compensated and subject to ever increasing administrative burdens.

Further, oversight of these programs should be coordinated at the state level. The MHCC HMO Report Card initiative, the HSCRC P4P initiative, the Governor's Quality Council, and other programs already play an important role in quality improvement and oversight

III. RECRUITMENT:

Greater Flexibility for LARP (Option 10.2)

- Expand loan forgiveness programs targeted at "shortage areas" and/or "shortage specialties" beyond the limited MUA/HPSA designated areas.

- Allow other "nonprofit" organizations, such as hospitals, nursing homes, clinics, hospices, etc., to sponsor a physician for loan assistance reimbursement program (LARP) purposes.

  Rationale: LARP is a collaborative effort among state and federal entities that offers physicians an opportunity to practice in a community that lacks adequate primary and/or mental health care services, while also paying off their educational loans. The amount of the loan assistance provided varies in accordance with the number of years of service a physician agrees to provide. Eligible primary care practitioners include those who are board certified or have completed a residency in family practice, OB/GYN, internal medicine, pediatrics, or general psychiatry and who are employed in a non-profit setting.

Limiting opportunities for loan assistance repayment to those physicians who agree to work in a non-profit setting severely limits recruitment efforts in shortage areas. The focus should be on the broader issue of addressing the shortages in these areas for the long term. Allowing a physician to establish a private practice in a shortage area while qualifying for loan repayment assistance would facilitate the retention of that physician in that community on a long term basis.

Funding Options for LARP Expansion (Options 10.2, 10.3)

- Adjust the current assessment on physician licenses to expand and/or increase flexibility of LARP.

  Rationale: Currently, 14 percent of the physician license fees (12 percent beginning in FY 2009) are dedicated and split between two programs: 1) grants under the Health Manpower Shortage Incentive Grant Program; and, 2) the Loan Assistance Repayment Program for primary care physicians. For FY 2008, the grants awarded under the Health Manpower Shortage Incentive Grant Program totaled $499,098, and were split between 39 different postsecondary institutions. The LARP for primary care physicians in FY 2008 totaled $432,500, with an average of $25,441 provided to 17 physicians.

- Allow hospitals in shortage areas to establish loan forgiveness approaches under the all-payor system in exchange for a commitment to practice in the shortage area—similar to the Nurse Support Programs I and II.

  Rationale: Generating additional revenue from all payors for the state portion of LARP funding could be used to draw down additional federal funding and/or establish a state program with greater flexibility.
- Allocate a portion of fines assessed by the MIA for health care carrier violations of certain consumer protection laws to LARP.

  Rationale: Linking a portion of fines assessed by the MIA to LARP would better align incentives towards creating a better physician climate in Maryland.

Teaching Programs

- Encourage teaching programs to offer greater exposure to family practice settings, greater exposure to specialties in short supply, and rotations in shortage areas.

  Rationale: Focusing on the types of specialties in short supply, including family medicine, and exposure to shortage area practice settings could generate interest at the medical school level (before residencies/specialties are selected). Early identification of students with an interest in practicing in shortage areas would also be useful in earlier identification of students with an interest in those types of settings.

IV. FEDERAL INITIAITVES:

Increase Number of Residency Slots

- Increase the number of residency slots/programs in Maryland.

  Rationale: The 1997 Balanced Budget Act froze the number of residency positions the Medicare program would support to more closely align it with the number of graduates of U.S. medical schools. The failure of tightly organized managed care and the aging of the US population have now led to calls for reconsideration of that policy. In 2006, the AAMC recommended a 30 percent increase in medical student enrollment and a 15 percent increase in the number of Medicare-supported GME positions. In addition, both MedPac and COGME, have suggested that policymakers focus on the number of residency slots/resources devoted to family medicine.

  The number of all applicants, including graduates of foreign medical schools and colleges of osteopathy, has declined for a decade and has decreased precipitously among graduates of US medical schools. In 1997, of the 3,262 training positions in family medicine, 2,905 (89.1 percent) were filled—71.7 percent by graduates of US medical schools. In 2008, of the 2,654 residency positions offered in family medicine, 2,404 (90.6 percent) were filled, but only 1,172 (44.2 percent) were filled by graduates of US schools.

Expand Residency Training Venues

- Broaden definition of eligible "training venues".

  Rationale: Medical practice and education are shifting more to the ambulatory setting for both primary and specialty care services but GME funding continues to be primarily tied to inpatient hospital care. Adding additional training venues would better reflect the shift to ambulatory settings and likely increase the number of eligible venues in rural areas.

Loan Assistance Repayment Programs (LARP)

- Provide flexibility in the federal LARP requirements to allow physicians in private practice settings in shortage areas to qualify for the program.

  Rationale: LARP is a collaborative effort among state and federal entities that offers physicians an opportunity to practice in a community that lacks adequate primary and/or mental health care services, while also paying off their educational loans. The amount of the loan assistance provided varies in accordance with the number of years of service a physician agrees to provide. Eligible primary care practitioners include those who are board certified or have completed a residency in family practice, OB/GYN, internal medicine, pediatrics, or general psychiatry and who are employed in a non-profit setting.

  Limiting opportunities for loan assistance repayment to those physicians who agree to work in a non-profit setting severely limits recruitment efforts in shortage areas. The focus should

be on the broader issue of addressing the shortages in these areas for the long term. Allowing a physician to establish a private practice in a shortage area while qualifying for loan repayment assistance would facilitate the retention of that physician in that community on a long term basis.

National Health Service Corps

- Restore/expand funding for the National Health Service Corps (NHSC) Scholarships and Loan Repayment.

  Rationale: Since its inception in 1972, the NHSC has supported over 28,000 primary and dental professionals through scholarships and loans repayment in return for service in HPSA-designated areas. Service commitment is a minimum of two years, and salaries are covered by the place of employment. In FY 2006, 4,109 health care professionals were participating in the NHSC scholarship and loan repayment program. At the same time, the NHSC Jobs Opportunity List for FY 2008 indicated that 4,888 positions went unfilled because of a lack of funding to support them.

  Despite the number of unfilled positions, federal appropriations for the NHSC have steadily declined—from a peak of $169.9 million in FY 2004 to $123.5 in FY 2008. At $121 million, the Administration's FY 2009 request continues this trend.

J-1 Visa Program

- Revitalize the J-1 visa program**.**

  Rationale: The J-1 Visa allows foreign nationals to enter the U.S. for educational purposes and requires that they then return to their home country for two years before applying for a U.S. immigrant visa, permanent residence, or another type of visa. The State Department issues waivers to the return-home requirement for primary care physicians who practice in designated HPSAs. A GAO survey of the states found that in 2005 there were 3,128 waiver physicians practicing in underserved areas – significantly higher than the number of U.S. physicians participating in the NHSC.

  Over the last several years, however, the number of J-1 Visas has declined, triggered in large part by the expansion of H1-B work-related visas and a real preference among residency programs to take H1-B foreign trained US citizens over J-1 Visa physicians. Policy changes are needed to revitalize or replace this vital pipeline to underserved communities.

Telemedicine

- Seek Medicare reimbursement for a broader range of telemedicine services.

  Rationale: Medicare currently limits reimbursement for telemedicine to "interactive clinical services that otherwise would be provided face-to-face." Monitoring chronic disease at home, providing continuing medical education to local providers in rural areas, clinical

integration, improving communication among providers, payors, and patients, etc., all have the potential to significantly improve the efficiency and effectiveness of health care delivery in shortage areas.

Expand MUA/HPSA Designations

- Revise criteria for MUA/HPSA designations to qualify additional shortage areas for designation in Maryland.

  Rationale: Obtaining a federal designation as a Medically Underserved Area/Population (MUA/P) or Health Professional Shortage Area (HPSA) makes them eligible for multiple federal program resources and benefits; e.g., FQHCs, J-1 Visa, Loan Assistance Repayment, National Health Service Corps, enhanced Medicaid and Medicare reimbursement.

  The current regulations, however, are complex and limited in scope as to what geographic areas would qualify as well as what professionals are included. Expanding the scope of these programs would enable shortage areas to attract other types of medical professionals needed in their communities and facilitate the location of professionals in emerging shortage areas.

  Providing additional resources to state offices of rural health may be appropriate to ensure timely designations of these shortage areas.